

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

## CERTIFICATE OF DEATH

04823

Reg. Dist. No. 51

FILE # G 96 JUL 19 1945

### 1. PLACE OF DEATH:

County Calvert

City or town Huntingtown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Calvert

City or town Huntingtown  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Jane Coats

### 3. (b) Social Security Number

4. Sex

F

5. Color or race

C.

6. (a) Single, married, widowed, or divorced

X

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Dec. 24, 1966

8. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

79-78

hrs. min.

9. Birthplace

md.

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

FATHER  
MOTHER

12. Name

Louis Banks

13. Birthplace

md.

14. Maiden name

Harriet Gross

15. Birthplace

md.

16. Informant

Rosa Mackall

Address

Huntingtown

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof 5-26-45  
(month) (day) (year)

Cemetery or crematory

Calvert

Location

Calvert

18. Funeral director

P. E. Sewell

Address

Paince Frederick, Md.

19. (Date rec'd by registrar)

5-25-45

19 45

C. V. Jarvis

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH

5-23-1945 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-21

1942 to 23 May 1945

and that I last saw her alive on

23 May 1945

Immediate cause of death

cardio vascular and  
diarrhea

Due to

obstruction

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

[Signature]

M. D. or other

Address

Huntingtown

Date signed 25 May 45

RECEIVED  
JUL 13 1945  
BUREAU V.B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH: *Calvert*  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....  
Hospital, institution, or street address where death occurred:  
.....  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State.....*md* County.....*Calvert*  
City or town.....*Island Creek*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2(a) If veteran, name war.....

3. (a) FULL NAME  
*David Green*

3. (b) Social Security Number

4. Sex.....*m.* 5. Color or race.....*C.* 6. (a) Single, married, widowed, or divorced.....*X*  
B. (b) Name of husband or wife.....*Jennie Green*  
7. Birth date of deceased (mo., day, yr.).....*P Unknown* 8. (c) If alive, give age.....*75* years  
8. AGE: Years.....*67* Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....*md* (Town, county, and state)  
10. Usual occupation.....*Farmer*  
11. Industry or business.....  
12. Name.....*? Unknown*  
13. Birthplace.....*Unknown*  
14. Maiden name.....*? Unknown*  
15. Birthplace.....*? Unknown*

16. Informant.....*Jennie Green*  
Address.....*Island Creek*  
17. *Burial* Date thereof.....*5-13-45*  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory.....*St. Philip Point*  
Location.....*Calvert*  
18. Funeral director.....*P.E. Sewell*  
Address.....*Prince Frederick*  
19. *5-13* 19. *45* *P. N. King* *md*  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....*May 10* 19. *45* at.....*10:30 A.M.*  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....*April 15* 19. *43* to.....*19*  
and that I last saw him alive on.....*May 10* 19. *45*  
Immediate cause of death.....*Senile Dementia*  
*Paranoid & Del.*  
Due to.....*Arteriosclerosis*  
Due to.....  
Other conditions.....  
(Include pregnancy within 8 months of death)

Major findings of operations.....  
Date of op.....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur?..... (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury..... Injured at work?  
23. SIGNATURE.....*Page 128*  
Address.....*Prince Frederick, Md.* Date signed.....  
M. D. or other

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 15 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
age of deceased is shown  
on

FILM NO. G 97 JUL 27 1945

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89a

## CERTIFICATE OF DEATH

04825

Reg. Diat. No. 51

### 1. PLACE OF DEATH:

County Calvert

City or town Willows  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Safe

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Calvert

City or town Willows  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Heanna Harris

### 3. (b) Social Security Number

4. Sex F 5. Color or race C 6.(a) Single, married, widowed, or divorced X

8.(b) Name of husband or wife Samuel Harris

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Oct 26, 1889

8. AGE: Years 55 Months 56 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace md  
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business \_\_\_\_\_

FATHER 12. Name Elijah Smith

13. Birthplace md

MOTHER 14. Maiden name Eliza Harrod

15. Birthplace md

16. Informant Samuel Harris

Address Willows, md

17. Burial Date thereof 5-6-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Edmonds

Location Calvert

18. Funeral director P. E. Sewell

Address Prince Frederick Md

19. 5-4 19 45 C. V. Jarvis  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 5-3-1945 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1 May 1945 to 3 May 1945 and that I last saw her alive on 3 May 1945

Immediate cause of death cerebral accident

Due to Hypertension

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury fall from Injured at work? \_\_\_\_\_

23. SIGNATURE [Signature] M. D. or other \_\_\_\_\_

Address Heidelberg Date signed 5 May 45

DR. GEO. J. WEISS  
Huntingtown, Md.

RECEIVED  
JUL 13 1945  
BUREAU V. B.

DR. GEO. J. WEISS  
Huntingtown, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04826

Reg. Dist. No.

52

## 1. PLACE OF DEATH:

County CecilCity or town Prince Frederick  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

7

5. Color or race

C

6. (a) Single, married, widowed, or divorced

S

8. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

5. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

8 hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial, cremation, or removal. Which?

Cemetery

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

19

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

5

14

19

41-620P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/14

41

to

5/14

19

41-620P M

and that I last saw him alive on

5/14

19

41-620P M

Immediate cause of death

Coronary heart

DURATION

8 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED  
JUN 13 1945  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (702)

## CERTIFICATE OF DEATH

04827

Reg. Dist. No. 52

## 1. PLACE OF DEATH:

County CalvertCity or town Burien  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CalvertCity or town Burien  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Harold C. MarcellusMarcellus

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

S

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

March 21 1925

8. AGE:

Years 20Months 1Days 25

If less than one day

hrs. \_\_\_\_\_

min. \_\_\_\_\_

9. Birthplace

Ind

(Town, county, and state)

10. Usual occupation

John

11. Industry or business

MOTHER FATHER

12. Name

Charles C. Marcellus

13. Birthplace

Ind

14. Maiden name

Sadie Catterton

15. Birthplace

Ind

16. Informant

Wife Sadie Marcellus

Address

Owings

17.

(Burial, cremation, or removal, Which?)

Date thereof

May 16 - 45

(month) (day) (year)

Cemetery or crematory

Cemetery

Location

Mt. Harman

18. Funeral director

W. H. Hulseberg

Address

Owings, Md.

19.

(Date rec'd by registrar)

May 16 1945W. Hulseberg

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 5/13 1945 at 7 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

Broken neck  
both days  
curled short

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5/12/45Where did injury occur? Burien Calvert Ind  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HighwayMeans of injury with ax Injured at work? Yes

23. SIGNATURE

Owings Ind

M. D. or other

Address \_\_\_\_\_ Date signed \_\_\_\_\_

RECEIVED

JUN 13 1945

BUREAU V.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 330

## CERTIFICATE OF DEATH

Reg. Diat. No. 04828 51

## 1. PLACE OF DEATH:

County Cabot  
 City or town Prince Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
Cabot Co. Hospital  
 How long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md County Cabot  
 City or town Prince Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2(a) If veteran, name war ms

## 3. (a) FULL NAME

Ernest W. Rawlings

## 3. (b) Social Security Number

216-16-4809

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

M

## 6. (b) Name of husband or wife

Sarah Ellen Rawlings

## 6. (c) If alive, give age

64 years

## 7. Birth date of deceased (mo., day, yr.)

Mar. 25, 1884

## 8. AGE:

Years

Months

Days

If less than one day

61116

hrs.

min.

## 9. Birthplace

Cabot Co., Md.  
(Town, county, and state)

## 10. Usual occupation

Squad - at Naval Station

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Daniel F. Rawlings

## 13. Birthplace

Md

## 14. Maiden name

Rachel Smith

## 15. Birthplace

Md

## 16. Informant

Daniel Rawlings

## Address

Prince Frederick, Md

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

May 13, 1945  
(month) (day) (year)

## Cemetery or crematory

Wesley

## Location

Prince Frederick, Md

## 18. Funeral director

A. B. Harrison & Son

## Address

Montreal, Md.

## 19.

5-13  
(Date rec'd by registrar)1943J. N. King

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

May 11, 1945 at 11:2 M

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 6, 1945 to 1945 and that I last saw him alive on 1945

## Immediate cause of death

Cerebral Hemorrhage (right) 12 hours

## DURATION

## Due to

Hypertension

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Ray Jett M. D. or other  
Prince Frederick Date signed May 13

RECEIVED  
MAY 15 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

## 1. PLACE OF DEATH:

County CabotCity or town St. Leonard's  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 1/2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County AdamsCity or town Brooklyn Heights  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Anna May Rodey

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Edward C. Rodey7. Birth date of deceased (mo., day, yr.) Jan. 29, 18956. (c) If alive, give age 51 years8. AGE: Years 50 Months 3 Days 9 It less than one day  
.....hrs. ....mo.9. Birthplace Phila. Pa  
(Town, county, and state)10. Usual occupation Home

11. Industry or business

12. Name Jenkins

13. Birthplace

14. Maiden name Martha Keays

15. Birthplace

16. Informant Edward C. RodeyAddress St. Leonard's Ind17. Burial Date thereof May 11, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. PaulsLocation Lucy, Ind18. Funeral director A. H. Hackmuss & SonAddress Mutual, Ind19. 5-12 19 45 J. M. King

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1945 at 12:20 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28, 1945 to May 8, 1945and that I last saw him alive on May 8, 1945

Immediate cause of death

Malignant Hypertension+ UremiaDue to Acute Nephrosclerosis, svz. & r.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James J. Stettin M. D. or otherAddress James J. Stettin Date signed 5/8/45

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C.

RECEIVED  
MAY 15 1945  
BUREAU V.B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Diat. No. 04830 51

### 1. PLACE OF DEATH:

County Cabot  
 City or town Broomer Island  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Ind County Cabot  
 City or town Port Republic, Ind  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

### 3. (a) FULL NAME

Somerwell  
Anne Maria Somerwell

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 8.(b) Name of husband or wife Alexander Somerwell  
 6.(c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) Feb. 11, 1870  
 8. AGE: Years 75 Months 2 Days 21 If less than one day ..... hrs. .... min.  
 9. Birthplace Cabot County, Ind  
 (Town, county, and state)  
 10. Usual occupation Home

### 11. Industry or business

FATHER 12. Name Thomas Parvan  
 13. Birthplace Cabot County, Ind.  
 MOTHER 14. Maiden name Mary E. Soffers  
 15. Birthplace Cabot County, Ind.  
 16. Informant Mrs. John Tatifer  
 Address Broomer Island  
 17. Burial Date thereof May 4, 1945  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Christ Church  
 Location Port Republic, Ind  
 18. Funeral director A. A. Haskins & Son  
 Address Mutual, Ind  
 19. 52 19 45 J. N. King  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 2 May 19 45 at 2:05 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 March 19 45 to 2 May 19 45  
 and that I last saw him/her alive on 15 April 19 45  
 Immediate cause of death Myocardial failure  
 Due to Arterial fibrillation  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)  
 Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underwrite the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE Alexander M. D. or other  
 Address Port Republic Date signed 2 May 45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 7 1945

BUREAU V.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

## CERTIFICATE OF DEATH

Reg. Diat. No. 52

## 1. PLACE OF DEATH:

County CalvertCity or town Paris

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CalvertCity or town Paris

(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Thelma Elizabeth Stallings

## 3. (b) Social Security Number

4. Sex Female5. Color or race white

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife \_\_\_\_\_

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) May 1, 19268. AGE: Years 19 Months \_\_\_\_\_ Days 7 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Calvert County, Md.

(Town, county, and state)

10. Usual occupation Student

11. Industry or business \_\_\_\_\_

12. Name George Stallings13. Birthplace Calvert Co. Md.14. Maiden name Bearl Towles15. Birthplace Calvert Co. Md.16. Informant Mrs. Bearl StallingsAddress Paris, Md.17. Burial Date thereof 5 11 48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Mt. Harmony

Location \_\_\_\_\_

18. Funeral director W. H. HutchinsAddress Owings19. May 10 1948 W. H. Hutchins

(Date recd. by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1948 at 9:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 28 1945 to May 8 1948and that I last saw him alive on May 5 1948

Immediate cause of death \_\_\_\_\_

Thelma Elizabeth Stallingsis Thelma Elizabeth Stallings

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE George Stallings M. D. or other \_\_\_\_\_Address Paris, Md. Date signed 5/11/48

RECEIVED  
JUN 13 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1910

## CERTIFICATE OF DEATH

Reg. Dist. No. 52

## 1. PLACE OF DEATH:

County North BeachCity or town Down  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CalvertCity or town   
(If outside city or town limits, write RURAL and give nearest town)Street No.   
(If rural, give LOCATION)2.(a) If veteran, name war 

## 3. (a) FULL NAME.

Eugene Vincent Stewart

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Mrs Barbara Stewart7. Birth date of deceased (mo., day, yr.) 1882 6.(c) If alive, give age  years8. AGE: Years 63 Months  Days  If less than one day  hrs.  min.9. Birthplace Miss  
(Town, county, and state)10. Usual occupation Artist + Sign Painter

11. Industry or business

12. Name John Stewart13. Birthplace unknown14. Maiden name Florence Dayton15. Birthplace unknown16. Informant Mrs Barbara StewartAddress North Beach md17. (Burial, cremation, or removal, which?) Burial Date thereof 5/13/45  
(month) (day) (year)Cemetery or crematory CemeteryLocation Mt. Harmony18. Funeral director Wm. H. HutchinsAddress Quince Md19. (Date rec'd by registrar)  19. Grace Hutchins Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10 May 1945 at 2:25 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 April 1945 to 10 May 1945 and that I last saw him alive on 9 May 1945Immediate cause of death cardiovascular renal diseaseDue to arteriosclerosisDue to Other conditions 

(Include pregnancy within 8 months of death)

Major findings of operations Date of op. Autopsy results 

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of Where did injury occur?  (City or town)  (County)  (State)Injured at home, farm, industry, public place (where?) Means of injury  Injured at work? 23. SIGNATURE Glossner md M. D. or other Address Huntingtown Date signed 10 May 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (312)

## CERTIFICATE OF DEATH

04833 T

Reg. Dist. No. 51

## 1. PLACE OF DEATH

County CalvertCity or town Calvert md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CalvertCity or town Calvert md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Josephine Wallace

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

C.

6.(a) Single, married, widowed, or divorced

X

6.(b) Name of husband or wife \_\_\_\_\_

5.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Apr. 29, 1960

8. AGE:

Years

Months

Days

If less than one day

804

hrs.

min.

9. Birthplace md

(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business \_\_\_\_\_

FATHER

12. Name ?

13. Birthplace \_\_\_\_\_

MOTHER

14. Maiden name Barbara Coats15. Birthplace md.16. Informant Beatrice KentAddress Calvert md.17. (Burial, cremation, or removal. Which?) BurialDate thereof 5-4-45  
(month) (day) (year)Cemetery or crematory Brook's ChapelLocation Calvert18. Funeral director P.E. SewellAddress Prince Frederick, md19. 5-3 19 45

(Date rec'd by registrar)

J. M. King  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 5-2-1945 at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-1 19 45 to 29 April 19 45and that I last saw her alive on 29 April 19 45

Immediate cause of death

Hypertensive cardiovascular  
renal disease

DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE J. M. KingDeputy Medical Examiner for Cal. County  
M. D. or otherAddress Prince Frederick, Md. Date signed \_\_\_\_\_

RECEIVED  
MAY 4 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on

FILM No. G 96 JUN 29 1945

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 50

### 1. PLACE OF DEATH:

County..... Calvert

City or town..... Lusby, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Calvert

City or town..... Lusby, Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

### 3.(a) FULL NAME

Clarence Watts

### 3.(b) Social Security Number

4. Sex..... m. 5. Color or race..... c. 6.(a) Single, married, widowed, or divorced..... X

6.(b) Name of husband or wife..... Miss Katherine Watts

6.(c) If alive, give age..... 35 years

7. Birth date of deceased (mo., day, yr.)..... Nov. 3, 1916

8. AGE: Years..... 34-38 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... Calvert Co.  
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business.....

12. Name..... James Watt

13. Birthplace..... Md

14. Maiden name..... Ella Hutchins

15. Birthplace..... Md

16. Informant..... James Watt

Address..... Lusby Md

17. Burial..... Date thereof..... 5-21-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Johns

Location..... Calvert

18. Funeral director..... R.E. Sewell

Address..... 22 Prince Frederick Rd

19. Date signed by registrar..... May 21 1945

(Date read by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... 5-21-45 at 7:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to May 20 1945

and that I last saw h..... alive on May 19 1945

Immediate cause of death.....

Pulmonary Tuberculosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... P.C. Lett / Villanov

Address..... Prince Frederick Date signed 5/21/45

RECEIVED  
JUN 11 1945  
BUREAU V.S.